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BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against**:**	Case No. 1H-2009-568
CHRISTOPHER ERVIN LATRACE. **8373 Balsa Avenue** **Yucca Valley, CA 92284** **Respiratory Care Practitioner** **License No. 27153,** Respondent.	**A C CU S A T I O N**

Complainant alleges:

PARTIES

1. Stephanie Nunez (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Respiratory Care Board of California, Department of Consumer Affairs.

2. On or about January 29, 2008, the Respiratory Care Board issued Respiratory Care Practitioner License Number 27153 to Christopher Ervin LaTrace, R.C.P. (Respondent). The Respiratory Care Practitioner License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Respiratory Care Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 3710 of the Code states: "The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter [Chapter 8.3, the Respiratory Care Practice Act]."

5. Section 3718 of the Code states: "The board shall issue, deny, suspend, and revoke licenses to practice respiratory care as provided in this chapter."

6. Section 3750 of the Code states:

"The board may order the denial, suspension or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

"…

"(f) Negligence in his or her practice as a respiratory care practitioner.

"…

"(k) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any patient, hospital, or other record.

"…

"(p) A pattern of substandard care."

7. Section 3755 of the Code states:

"The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care. Unprofessional conduct includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision of Section 3750. The board

may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner."

COST RECOVERY

8. Section 3753.5, subdivision (a) of the Code states:

"In any order issued in resolution of a disciplinary proceeding before the board, the board or the administrative law judge may direct any practitioner or applicant found to have committed a violation or violations of law or any term and condition of board probation to pay to the board a sum not to exceed the costs of the investigation and prosecution of the case." A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the official custodian of the record or his or her designated representative shall be prima facie evidence of the actual costs of the investigation and prosecution of the case. "

9. Section 3753.7 of the Code states for purposes of the Respiratory Care Practice Act, costs of prosecution shall include attorney general or other prosecuting attorney fees, expert witness fees, and other administrative, filing, and service fees.

10. Section 3753.1 of the Code states:

"(a) An administrative disciplinary decision imposing terms of probation may include, among other things, a requirement that the licensee-probationer pay the monetary costs associated with monitoring the probation. "

FIRST CAUSE FOR DISCIPLINE

(Negligence)

11. Respondent is subject to disciplinary action under section 3750, as defined by 3750, subdivision (f) of the Code, in that respondent was negligent in his care and treatment of several patients identified below. The circumstances are as follows:

JFK Memorial Hospital (JFK)

A. From on or about February 4, 2008, to April 24, 2009, respondent was employed as a respiratory care practitioner at JFK Memorial Hospital (JFK). As part of his duties, respondent was assigned the care of several patients: Acct #4787048, Acct #5006260,

Acct #5005779, Acct #5031575, Acct #4787098, Acct #5037182, Acct #5097991, Acct #5158516, Acct #5142008, and Acct #5174457.[1]

February 10, 2009: Acct #4787048

B. On or about February 10, 2009, at 2226 hours, respondent removed medication from Pyxis (Xopenex, 1.25mg), and entered a billing indicating the medication was given to the patient. However, respondent failed to document he administered the treatment to the patient.

February 24, 2009:

Acct #5006260

C. On or about February 24 2009, at 2325 hours, respondent documented and billed he administered a treatment (Xopenex, 1.25mg) to the patient. In truth and in fact, respondent did not administer treatment because he never removed the medication from Pyxis.

Acct #5005779

D. On or about February 24, 2009, at 2325 hours, respondent documented he administered a treatment (Xopenex, 1.25mg) to the patient. In truth and in fact, respondent did not administer a treatment because he never removed the medication from Pyxis.

Acct # 5031575

E. On or about February 24, 2009, at 2315 hours, respondent documented and billed he administered a treatment (Xopenex, 1.25 mg) to the patient. In truth and in fact, respondent did not administer a treatment because he never removed the medication from Pyxis.

Acct # 4787098

F. On or about February 24, 2009, at 1900 hours, respondent documented and billed he administered a treatment (Albuterol Sulfate, 2.5 mg) to the patient. In truth and in fact, respondent did not administer a treatment because he never removed the medication from Pyxis.

On or about February 25, 2009, at 0100 hours, respondent documented giving another treatment (Albuterol Sulfate, 2.5 mg) to the patient. In truth and in fact, respondent did not

[1] Patients are identified by hospital account number.

administer a treatment because he never removed the medication from Pyxis and did not bill the patient for the treatment.

On or about February 25, 2009, at 0300 hours, respondent documented he administered another treatment (Albuterol, 2.5 mg) to the patient. This was false because the medication was not removed from Pyxis until 0305, and respondent billed he administered the treatment at 0400.

Acct #5037182

G. On or about February 24, 2009, at 1910 hours, respondent documented he administered a treatment (Albuterol Sulfate, 2.5 mg) to the patient. In truth and in fact, respondent did not administer the treatment because he did not remove the medication from Pyxis.

March 17, 2009:

Acct #5097991

H. On or about March 17, 2009, this patient was admitted with an order to receive an aerosol treatment with Pulmicort, 0.5mg Q12 hours and 0.5ml (2.5mg) of Albuterol Sulfate Q8 hours and prn (as necessary). Respondent documented he administed the Albuterol Sulfate medication but not the Pulmicort medication. This is false. In truth and in fact, respondent did not administer any treatment because he never removed either medication from Pyxis.

April 13, 2009:

Acct # 5158516

I. On or about April 13, 2009, at 2350 hours, respondent documented he administered a treatment (Xopenex, 1.25 mg) to the patient. This is false. In truth and in fact, respondent did not administer the treatment because he did not remove the medication from Pyxis until April 14, 2009, at 0008 hours[2].

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[2] Respondent also documented he administered a treatment to another patient (5142008, paragraph J below) at the same time he administered the treatment to this patient at 2350 hours.

Acct #5142008

J. On or about April 13, 2009, at 2350 hours, respondent documented he administered a treatment (Xopenex, 1.25 mg) to the patient. This is false. In truth and in fact, respondent did not administer the treatment because he did not remove the medication from Pyxis until April 14, 2009, at 0800 hours.[3]

Acct #5174457

K. On or about April 13, 2009, at 2330 hours, respondent documented he administered a treatment (Xopenex, 1.25 mg) to the patient. This is false. In truth and in fact, respondent did not administer the treatment because he did not remove the medication from Pyxis until April 14, 2009, at 0007 hours.

L. On or about April 24, 2009, respondent was terminated from JFK.

Hi-Desert Medical Center (HDMC)

M. On or about May 29, 2008 to March 18, 2009, respondent was employed as a respiratory care practitioner at Hi Desert Medical Center (HDMC). As part of his duties, respondent was assigned the care of several patients: Acct #V001744865, Acct #V001745438, Acct #V001742553, Acct #V001732667, Acct #V001745619, Acct #V001745609, Acct #V001745606, Acct #V001745581, Acct #V001745246, Acct #V001745550, Acct #V001745501, Acct #V001765608, Acct #V001778477, Acct #V001780656, and Acct #V001780845.

November 8, 2008

Acct #V01744865

N. This patient was admitted at HDMC with rapid heart beat. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93%. On or about November 8, 2008, respondent failed to check and/or document he checked the patient's oxygen saturation during the entire 12 hour shift.

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[3] Respondent also documented he administered a treatment to another patient (5158516, paragraph I above) at the same time he administered the treatment to this patient at 2350 hours.

Acct #V001745438

O. This patient was admitted at HDMC for a new onset of Atrial Fibrillation and was receiving 2 liters per minute of oxygen via a Nasal Cannula. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93%. Respondent failed to check and/or document he checked the patient's oxygen saturation the entire 12 hour shift.

Acct #V001742553

P. This patient was admitted at HDMC for diverticulitis and a sigmoid colon mass. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93%, and another order for Albuterol respiratory treatments Q6[4] hours. On or about November 8, 2008, respondent failed to check and/or document he checked the patient's oxygen saturation the entire 12-hour shift. Respondent also failed to administer the Albuterol treatment to the patient.

Acct #V001732667

Q. This patient was admitted for Menorrhagia. The physician ordered a Duoneb Q6 hours as needed for wheezing and cough. The patient received a treatment prior to respondent's shift on November 8, 2008, at 1400 hours, for wheezing and again after respondent's shift, at 0700 hours, for wheezing. Respondent failed to assess and/or document he assessed the patient during his 12 hour shift (1400-0700 hours). Respondent also failed to administer and/or document he administered any treatment to the patient during the 12 hour shift.

Acct #V001745619

R. This patient was admitted for a Gastrointestinal bleed and was receiving 4 liters per minute of oxygen via a Nasal Cannula. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93%. In addition, on November 8, 2008, at approximately 2200 hours, the patient received a new order for a Duoneb Q4 hours while awake (W/A). Respondent failed to check and/or document he checked the patient's

[4] Q = every

oxygen saturation the entire 12 hour shift. Respondent also failed to start and/or document he started the respiratory treatment before the patient went to sleep.

Acct #V001745609

S. This patient was admitted for Chronic Obstructive Pulmonary Disease and received 1 liter per minute of oxygen via a Nasal Cannula. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93%. In addition, on November 8, 2008, at 1800 hours, the patient received a new physician's order for Pulmicort 0.25mg/2ml. Respondent failed to start and/or document he started the Pulmicort respiratory treatment. Respondent also failed to check and/or document he checked the patient's oxygen saturation the entire 12 hour shift.

Acct #V001745606

T. This patient was admitted for Chronic Obstructive Pulmonary Disease and Congestive Heart Failure and receiving 3 liters per minute of oxygen via a Nasal Cannula. There was a physician's Oxygen Protocol, which was to maintain the patient's saturation >93%. On November 8, 2008, at 1835 hours, the physician ordered a Duoneb Q4 hours and as needed. Respondent failed to check and/or document he checked the patient's oxygen saturation the entire 12 hour shift. In addition, respondent did not start the new order until November 9, 2008, at 0500 hours.[5]

Acct #V001745581

U. This patient was admitted for a Pneumonia and Chronic Obstructive Pulmonary Disease and was receiving 4 liters per minute of oxygen via a Nasal Cannula. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93%. On or about November 8, 2008, at 1530 hours, the physician ordered Pulmicort 0.5mg/2ml for the patient. At 1750 hours, the physician ordered Duoneb as needed for the patient. Respondent failed to check and/or document he checked the patient's oxygen saturation the entire 12 hour shift. Respondent also failed to document he administered the ordered Pulmicort, and failed to

[5] According to the hospital/department policy new aerosol treatment must be started within four hours of being ordered.

assess and/or document he assessed the patient to determine if the patient needed the Duoneb treatment.

Acct #V001745246

V. This patient was admitted for Pneumonia. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93% as well as an order for Duoneb Q4 hours and as needed. Respondent failed to check and/or document he checked the patient's oxygen saturation the entire 12 hour shift. Respondent also failed to document he administered the respiratory treatments at 2330 and 0330 hours.

Acct #V001745550

W. This patient was admitted for chest pain and receiving 2 liters per minute of oxygen via a Nasal Cannula. There was a physician's order for the Oxygen Protocol, which was to maintain the patient's saturation >93%. Respondent failed to check and/or failed to document he checked the patient's oxygen saturation the entire 12 hour shift.

Acct #V001745501

X. This patient was admitted for dehydration and Gastroenteritis. The patient has a history of Muscular Dystrophy and was dependent on a ventilator for breathing. Respondent failed to check and/or document he checked the home ventilator the entire 12 hour shift. [6]

January 30, 2009

Acct #V001765608

Y. This patient was admitted for dehydration, fever, and pneumonia. There was a physician order for the Oxygen Protocol, which was to maintain the patient's saturation >93% and, another order for Xopenex 0.63mg Q6 hours, Pulmicort 0.25 mg/2ml Q12 hours, and Chest Physical Therapy (CPT) three times a day (TID). Respondent falsely documented he checked the patient's oxygen saturation, administered the Xopenex and Pulmicort treatments. In truth and in

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[6] The patient's record reflects that the ventilator was last checked on November 8, 2008, and not again until November 9, 2008, at 0800.

fact, respondent failed to administer these medications because the medications were not removed from Med Select.[7]

March 8, 2009

Acct #V01778477

Z. This patient was admitted for Biliary Colic and Cholelithiasis and was on two 2 liters per minute of oxygen via a Nasal Cannula. The patient had an order for the Oxygen Protocol, which was to maintain the patient's saturation >93% and another order for respiratory treatments with 2.5mg Albuterol Sulfate Q6 hours. Respondent documented he administered treatments March 8, 2009 at 2010 hours and March 9, 2009 at 0130 hours and checked the patient's oxygen saturation. In truth and in fact, respondent failed to administer the treatments because the medications were not removed from Med Select for two treatments. In addition, respondent failed to check and/or document he checked the patient's oxygen saturation.[8]

March 15, 2009

Acct #V001780656

AA. This patient was admitted for chest pain and to rule out a Myocardial Infarction and receiving 4 liters per minute of oxygen via Nasal Cannula. On March 16, 2009, at 0349, the patient had a new order for the Oxygen Protocol, which was to maintain the patient's saturation >93%. Respondent failed to monitor and/or failed to document he monitored the patient's saturation.

Acct #V001780845

BB. This patient was admitted for an abdominal wall mass and has a history of Chronic Obstructive Pulmonary Disease. The patient had an order for respiratory treatments with Xopenex 0.63mg Q6 hours. On March 9, 2009, at 0200 hours, respondent failed to administer and/or failed to document he administered the treatment to the patient.

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[7] The patient's grandmother informed the director the patient did not receive respiratory therapy the entire night shift.

[8] The patient complained she did not receive any treatments during the night shift.

SECOND CAUSE FOR DISCIPLINE

(Falsifying, Grossly Incorrect, or Inconsistent Entries)

12. Respondent is further subject to disciplinary action under section 3750, as defined by 3750, subdivision (k), of the Code, in that respondent made false and incorrect entries by documenting he monitored and administered treatments to patients, when in truth and in fact, he did not monitor or administer treatments, as more particularly described in paragraph 11, above, which is incorporated by reference as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Pattern of Substandard Care)

13. Respondent is subject to disciplinary action under section 3750, as defined by 3750, subdivision (p), of the Code, in that respondent engaged in a pattern of substandard care in that he committed negligence in his care and treatment of several patients; and also failed to monitor, administer and document treatment provided, as more particularly described in paragraphs 11 through 12, above, which are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

14. Respondent is subject to disciplinary action under section 3755 of the Code, in that respondent engaged in conduct that breaches the rules or ethical code of the medical profession or conduct which is unbecoming to a member in good standing of the practice of respiratory care, and which demonstrates an unfitness to practice respiratory care, as more particularly described in paragraphs 11 through 13, above, which are incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Respiratory Care Board issue a decision:

1. Revoking or suspending Respiratory Care Practitioner License Number 27153, issued to Christopher Ervin LaTrace, R.C.P.

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2. Ordering Christopher Ervin LaTrace, R.C.P. to pay the Respiratory Care Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

3. Taking such other and further action as deemed necessary and proper.

DATED: April 14, 2011

Original Signed by Liane Freels for:
STEPHANIE NUNEZ
Executive Officer
Respiratory Care Board of California
Department of Consumer Affairs
State of California
Complainant

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